**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

EMHS EMERGENCY
25 GROW AVENUE
MONTROSE PA 18801

**Respondent Name**
LIBERTY MUTUAL FIRE INSURANCE

**Carrier's Austin Representative Box**
Box Number 01

**MFDR Tracking Number**
M4-13-0991-01

**MFDR Date Received**
DECEMBER 17, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Please review the enclosed documentation. I have printed the claim status detail that documents that this was sent to you in a timely manner."

**Amount in Dispute:** $2,708.82

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "This is not a network claim. Charges in disputes were denied as not submitted in a timely manner. In reviewing the documentation submitted by provider we noticed a copy of the professional bill is actually dated 8/25/11. Although we have no record of having received this bill prior to March 5, 2012, DWC has previously accepted the date of bill as proof of timely submission. Therefore we are currently processing the $100 professional bill for reimbursement. The facility bill, however, is dated February 15, 2012 and we have found no record of any previously dated bill or otherwise proof of timely submission. Out of state providers are required to comply with Division rules. For this reason our position remains the same regarding the facility bill. Charges were not submitted within the 95 day filing requirement."

**Response Submitted by:** Liberty Mutual, PO Box 3423, Gainesville, GA 60503

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 3, 2011 | Emergency Room Services | $2,708.82 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers'
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- F286 – Date(s) of service exceed (95) day time period for submission per rule 408.027 and Bulletin no. B-0037-05A.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
- Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.

**Issues**

1. Was the request for medical fee dispute resolution submitted timely to the Division?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

**Findings**

1. The requestor provided services in the state of Pennsylvania on August 3, 2011 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. 28 Texas Administrative Code §133.307(c) states that requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (1) A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. (B)A request may be filed later than one year after the date(s) of service if: (i)a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability; (ii)a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or (iii)the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

   Review of the documentation finds that the Division received the request for medical fee dispute resolution on December 17, 2012; the disputed date of service is August 3, 2011. Further review finds no compensability, extent of injury or liability issues involved in the dispute. The Division finds that the dispute was submitted untimely; therefore, the dispute is not eligible for review by the Division.
3. The Division deems this dispute is not eligible for review; therefore, the requestor has waived the right to Medical Fee Dispute Resolution.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | August 23, 2013<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.